Lanphear (E.)

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GASTROSTOMY IN CARCINOMA OF THE CARDIAC ORIFICE.

BY EMORY LANPHEAR, M.D., PH.D.,
OF KANSAS CITY, MO.;
SURGEON TO UNIVERSITY DISPENSARY, ETC.

IN discussing the subject of "Carcinoma of the Cardiac Orifice of the Stomach," Lauenstein[1] does not approve of the establishment of a fistula whenever obstruction of the cardiac orifice, dependent upon carcinoma, is nearly or quite complete. The chief objection to operation for the formation of a fistula is that when the disease is so far advanced as to necessitate feeding by other means than by the mouth it becomes impossible to approximate the wall of the stomach to the abdominal parietes—the first step in a gastrostomy; and Lauenstein reports two cases in which the attempt was unsuccessful. I have a similar case to report—one in which, upon opening the abdomen, the carcinomatous stomach was so much shortened and so closely adherent to its original position, because of the attachment of the cardiac tumor, that it was impossible to bring any portion of the anterior wall of the stomach in apposition with the thoracic or abdominal wall.

Mr. B., a patient of Dr. C. F. Wainwright, about fifty years old, for fifteen months had presented a clear clinical history of carcinoma of the esophageal extremity of the stomach. For three months there had been great

[1] Centralblatt für Chirurgie, vol. xviii, No. 27, p. 513.

difficulty in getting even liquid food into the stomach, and for three weeks the patient could not swallow any food at all. He was nourished by enemata, but he rapidly emaciated; the abdomen was scaphoid; a small tumor could be detected in the region of the cardiac orifice of the stomach; the esophageal tube was arrested at a distance of thirty-eight centimeters from the superior dental arch.

With Dr. Wainwright assisting and Dr. J. H. Thompson giving ether, laparotomy was performed June 20, 1892. A large nodular mass was found surrounding the cardiac extremity, while the upper third of the stomach was likewise involved in the growth. The stomach was shortened to less than half the normal size and bound by adhesions to the surrounding structures. Every attempt to draw the anterior wall of the stomach into apposition with the abdominal incision caused sudden and complete cessation of respiration. After several attempts, each followed by artificial respiration, the abdomen was closed by catgut sutures and dressed with bichloride gauze held in place by plaster. The operation occupied twenty-eight minutes. The patient was put to bed, without much shock. On June 21st, there were no visible effects of the operation, the condition being the same as before. Rectal feeding was continued. On June 29th, the patient had completely recovered from the operation; the wound had healed by primary union. Absolutely no pain was felt at any time after the operation. The patient continued to sink, however, and died July 6th. The autopsy disclosed carcinoma of the lower extremity of the esophagus and of the cardiac extremity of the stomach. The adhesions were strong and extensive. The stomach was much reduced in size, but apparently in such a condition that some food might have been digested if gastrostomy had been successful.

The want of success in such cases as this, it seems to me, should not discourage operators from trying to es-

tablish fistulæ for carcinoma affecting the cardiac orifice, for experience has demonstrated that often some benefit may be derived; but care must be exercised in the proper performance of the operation, for, as Lauenstein observes, the fistula must be so made as to admit of the ready introduction of food and at the same time retain the gastric juice, as otherwise the patient will be worried by attempts at feeding and the edges of the wound will become excoriated by the outpouring of the stomach's contents.

Even when it is possible to complete the gastrostomy the operation may be a total failure, as some stomachs will be found to have disturbed chemical conditions—as the absence of hydrochloric acid; this, however, is quite rare, and cannot be regarded as a legitimate objection to an operation that holds a certain degree of hope of greatly prolonging life and is attended with but trifling danger—practically none at all in skilled hands.

Carcinoma of the stomach is not a rare disease; if diagnosticated early it is susceptible of removal, if it affect the pylorus or lesser curvature; if it involve only the cardia, early gastrostomy, before contractions and adhesions have taken place, will greatly prolong life. The relative situation, according to Welch,[1] in a total of 1300 cases analyzed, was: Pyloric region, 791; lesser curvature, 148; cardia, 104; posterior wall, 68; whole of stomach, 61; multiple tumors, 45; greater curvature, 34; anterior wall, 30; fundus, 19. Thus, a large proportion of cases, if recognized early, are within reach of the surgeon's knife for extirpation; if diagnosticated later, for gastro jejunostomy when the pylorus is obstructed, for gastrostomy when the occlusion occurs at the cardiac orifice. I cannot too strongly urge the necessity for early diagnosis and the calling of a surgeon before the case has progressed so far as to render surgical interference useless.

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[1] System of Medicine, vol. ii. Philadelphia, 1886.